Commonwealth of Massachusetts
Division of Professional Licensure
Office of Public Safety and Inspections
ELEVATOR INCIDENT REPORT

E-mail to: elevator.supervisor@mass.gov

You must report all elevator accidents or unsafe conditions to the Office of Public Safety and Inspections within 48 hours. You may report either through IPS Customer Portal, or by e-mailing this form to: elevator.supervisor@mass.gov

Note: Accidents involving serious injury or serious mechanical failure must also be reported by telephone at (508) 820-1444 within one hour of occurance or promptly upon first learning about the accident (see 524 CMR 4.01)

PLEASE PROVIDE COMPLETE INFORMATION BELOW

Elevator Owner:		**Elevator State ID#**	
Elevator Location Address:		**Incident Location:**	
		Certificate Expiration Date:	
Elevator Owner Contact Name:		**Date of Incident:**	
Elevator Owner Phone #:		**Time of Incident:**	
Elevator Owner E-mail:			
Elevator Company Name:			
Date of First Report to Office of Public Safety:		**Time of First Report to Office:**	
Name of Person Filing Report (if different than Owner Contact):		**Phone # (if different than Owner Contact**	
How was owner notified of the incident?			

Was the elevator taken out of service at the time of the incident? ☐ **Yes** ☐ **No**	**Has the elevator been put back into service?** ☐ **Yes** ☐ **No**	**If yes, on what date was the elevator put back in service and who authorized its reactivation?**

WITNESS INFORMATION

WITNESSES	**Name of Witnesses or Persons Present**	**Address**	**Phone**

INCIDENT/VICTIM INFORMATION

INJURED 1	**Name of injured:**	**Telephone Number:**	**Sex:** ☐ **Female** ☐ **Male**
	DOB:	**Street Address:** **City/State/Zip Code**	
	Was there an on-scene medical provider? ☐ **Yes** ☐ **No**	**If yes, on-scene medical provider's name and telephone #:**	
	Hospitalized? ☐ **Yes** ☐ **No** **Nature of injury:**		

INJURED 2	**Name of injured:**	**Telephone Number:**	**Sex:** ☐ **Female** ☐ **Male**
	DOB:	**Street Address:** **City/State/Zip Code**	
	Was there an on-scene medical provider? ☐ Yes ☐ No	**If yes, on-scene medical provider's name and telephone #:**	
	Hospitalized? ☐ **Yes** ☐ **No** **Nature of injury:**		

INJURED 3	**Name of injured:**	**Telephone Number:**	**Sex:** ☐ **Female** ☐ **Male**
	DOB:	**Street Address:** **City/State/Zip Code:**	
	Was there an on-scene medical provider? ☐ **Yes** ☐ **No**	**If yes, on-scene medical provider's name and telephone #:**	
	Hospitalized? ☐ **Yes** ☐ **No** **Nature of injury:**		

INCIDENT SUMMARY

Name of person filing report: **Date:**

By typing your name above you agree that this is valid as your signature.